Medicaid ACH-PCS Cost Settlement

Adult Care Home 6 Beds or Less

2005 - 2006

REPORT DUE DATE: JANUARY 31, 2007

Facility Name: _____ Facility Address: _____

County: _____ City, State, Zip Code: _____

License Number: _____ Medicaid Provider Number: _____

FID Number: _____ Cost Reporting Period: From _____ Through _____

Line #	ITEM		AMOUNTS
1.	Total: Personal Care Service Cost		1.
2.	Total: Administration Cost		2.
3.	Total: General Services Cost		3.
4.	Total: Allowable Administration Cost	**[Line #2 minus Line #3]**	4.
5.	Total: Facility Costs		5.
6.	Total: Facility Costs less Total Allowable Administration Cost	**[Line #5 minus line #4]**	6.
7.	Administration Cost Factor	**[Divide Line #4 by Line #6]**	
8.	Loaded PCS Costs	**[Multiply Line #1 by (Line #7 + 1.00)]**	
9.	Resident Days		9.
10.	SA (Medicaid) Days		10.
11.	Medicaid %	**[Divide Line #10 by Line #9]**	
12.	Medicaid Loaded PCS Cost	**[Multiply Line #8 by Line #11]**	
13.	Medicaid PCS Payment		13.
14.	Balance Now Due:	**[Line #13 minus Line #12 but do not enter less than $ 0.00]**	

Line #	Cost Report Schedule References
1.	Schedule C1, Line 20, Column 3
2.	Schedule C1, Line 120; Column 3
3.	Schedule C1, Total of Column 3; Lines 82, 105, 106, 107, 108, and 109.
5.	Schedule C1, Line 150, Column 3
9.	Schedule A, Line 19
10.	Schedule A, Line 20
13.	Schedule B, Line 4

Unpaid Owner/Operator Hours Cost Report Schedule References	
	List
Schedule C1, Line 20, Column 2	
Schedule C1, Line 40; Column 2	
Schedule C1, Line 80; Column 2	
Schedule C1, Line 120; Column 2	
Schedule C1, Line 140, Column 2	

Signature of person filling out the form: _____

Telephone Number: _____

Date: _____

MAIL FORM AND BALANCE DUE PAYABLE TO:

Division of Medical Assistance
Attention: Elizabeth Grady
2501 Mail Service Center
Raleigh, NC 27699-2501
Phone: (919) 855-4207 Fax: (919) 715-2209

THIS FORM IS NOT TO BE COMPLETED BY FAMILY CARE HOMES [LICENSE TYPE FCL]